CHILD'S NAME:	CASE NUMBER:

7. The child's relevant psychiatric history is as follows *(specify current behaviors likely to be helped by psychotropic medication)*:

☐ Continued on Attachment 7.

8. Other treatment interventions in addition to the requested medication(s) are:
   ☐ Individual therapy ☐ Group therapy ☐ Family therapy ☐ Other *(describe)*:

9. The following psychotropic medication is recommended:
   a. Name *(trade and generic)*:
   b. Category:
   c. Anticipated range of dosage:
   d. Anticipated treatment duration:
   e. Alternative medications in same category *(specify name of drug)*:
   f. Anticipated benefits to the child *(specify)*:
   ☐ Medication is approved for pediatric use.

☐ Continued on Attachment 9.

10. The relevant medical and medication history of the child is as follows *(specify all medication the child is currently taking, including prescription and nonprescription medications)*:

☐ See Attachment 10.

   a. The possible interaction with the recommended medications is as follows *(specify all possible effects of combining the medications)*:

☐ See Attachment 10a.

   b. The administration of the requested psychotropic medications will require the following adjustments of the current regimen of medications *(specify any discontinuations or changes in dosages)*:

☐ See Attachment 10b.

11. Significant adverse reactions, warnings/contraindications, drug interactions, withdrawal symptoms, and anticipated time lag before full effect for each recommended medication are
   ☐ attached as narrative.
   ☐ attached as document prepared by manufacturer or health care provider.

12. ☐ The child has been informed of this request, the medications that are recommended, their anticipated benefits, and their possible adverse reactions. The child's response was *(describe)*:

☐ Continued on Attachment 12. *(Child's own written statement may be included.)*

CHILD'S NAME:	CASE NUMBER:

13. a. The child's ☐ mother ☐ statutorily presumed father ☐ legal guardian has been informed of this request, the medications that are recommended, their anticipated benefits, and possible adverse reactions.
    b. ☐ No parent or guardian has been informed because (*state reasons*):

    c. ☐ The response of the parent or guardian was as follows:

    ☐ Continued on Attachment 13c.

    d. ☐ A parent or legal guardian has not received notice because their whereabouts are unknown.

14. ☐ All attorneys of record have been informed of this request.
    a. ☐ The mother's attorney ☐ does not oppose ☐ opposes the application and requests a hearing.
    b. ☐ The father's attorney ☐ does not oppose ☐ opposes the application and requests a hearing.
    c. ☐ The child's attorney ☐ does not oppose ☐ opposes the application and requests a hearing.

15. ☐ The child's present caregiver has been informed of this request, the medications that are recommended, their anticipated benefits, and possible adverse reactions. The response of the caregiver was as follows:

    ☐ Continued on Attachment 15.

16. ☐ A psychiatrist has reviewed this application.
    ☐ The psychiatrist agrees.
    ☐ The psychiatrist does not agree.

_____
(Signature of psychiatrist)

17. ☐ Other professionals who were informed and consulted *(state names and professional relationship to the case)*:

18. Other information or comments:

    ☐ Continued on Attachment 18.

Date:

_____ ▶ _____
(TYPE OR PRINT NAME) (SIGNATURE OF APPLICANT)

CHILD'S NAME:	CASE NUMBER:

ORDER

☐ The matter is set for hearing within 5 court days on *(date)* at *(time)*:
The clerk is to notice all parties and counsel.

☐ The application for authorization to administer psychotropic medications is:

- ☐ Granted as requested
- ☐ Denied
- ☐ Granted, with the following modifications or conditions:

☐ The court finds that the parent poses no danger to the child and has the capacity to authorize the administration of psychotropic medications, and the request for such authority is granted

- ☐ As requested
- ☐ With the following modifications or conditions:

☐ This order for authorization is effective until terminated or modified by court order or until 180 days from this order, whichever is earlier. If the physician named above is no longer treating the child, the authorization may extend to physicians who subsequently treat the child. If a new treating physician proposes an increase in the dosage or a change in or the addition of other medications, a new application must be submitted.

Date:

(TYPE OR PRINT NAME)

(JUVENILE COURT JUDICIAL OFFICER)

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name and Address)*:	*FOR COURT USE ONLY*
TELEPHONE NO. *(Optional)*: FAX NO. *(Optional)*: E–MAIL ADDRESS *(Optional)*: ATTORNEY FOR *(Name)*:	
SUPERIOR COURT OF CALIFORNIA, COUNTY OF STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME:	
CHILD'S NAME:	
OPPOSITION TO APPLICATION FOR ORDER FOR PSYCHOTROPIC MEDICATION—JUVENILE	CASE NUMBER:

1. I, , oppose the application because:

2. I am ☐ a party.
   ☐ an attorney for
   ☐ other (*specify*):

(This form must be returned immediately to the court within 2 court days of notice of the *Application for Order.*)

PSYCHIATRIC/MEDICATION EVALUATION

WHEN: At the time a child/youth is evaluated for medication.

ON WHOM: Every child/youth who receives a psychiatric evaluation for medication.

COMPLETED BY: MD / DO

MODE OF COMPLETION: Legibly handwritten, typed, or word processed on Psychiatric / Medication Evaluation form (MHS-645).

REQUIRED ELEMENTS: Top box shall include the date of service, CPT or HCPCS Code, location of service, Provider Staff ID number, face to face time, total time, DSM-IV-TR Code(s), and corresponding ICD-9-CM Billing Code(s).

The Evaluation shall also include the client's identifying data, which includes the client's age, sex, DOB, and treating therapist. The history of present illness shall be described, as well as substance use history, past psychiatric history (hospitalizations, suicide attempts and treatments), prior psychotropic medications, family psychiatric history, developmental history, past medical history (operations, hospitalizations, and allergies), current medications (effectiveness & compliance), outline of pediatrician's name and date of last physical, a mental status exam, lab test results when applicable and physical findings (including height, weight, pulse, and blood pressure when applicable), diagnostic impression (all five axis), and a plan (covering diagnostic examinations, laboratory tests, target symptoms, psychotherapeutic needs, medications, ongoing plan or other issues). Notation of medication side effects being discussed, and medication consent or an ex-parte obtained. Finally the return appointment shall be noted followed by the psychiatrist's signature, printed name, credentials, and date evaluation was completed.

T Bar shall be completed with the client's name, InSyst number, and program name.

BILLING: After rendering a service, the Psychiatric/Medication Evaluation Form numbered MHS-645 is to be completed adhering to the above documentation standards. The evaluating physician shall complete the Physician-Nurse Billing Record (See Billing portion of Progress Note section).

Date of Service:	CPT/HCPC Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Jail, 9=Inpatient.
Provider Staff ID:	Face to Face Time: HR: MIN:	Total Time: HR: MIN:
DSM-IV-TR Diagnosis Code(s):	ICD-9-CM Billing Code(s):	

I. Identifying Data:

Age	Sex	D.O.B.	Treating Therapist

II. History of Present Illness: _____

III. Substance Use History: _____

III. Past Psychiatric History (hospitalizations, suicide attempts, treatments): _____

IV. Prior Psychotropic Medications: _____

V. Family Psychiatric History: _____

VI. Developmental History: _____

VII. Past Medical History (operations, hospitalizations, allergies): _____

VIII. Current Medications (effectiveness, compliance): _____

Pediatrician:	Last Physical:

IX. **Mental Status Exam:** _____

_____

_____

_____

_____

X. **Lab Test Results / Physical Findings:** _____

_____

Height	Weight/lbs.	Kg (when applicable)	Pulse (when applicable)	Blood Pressure (when applicable)

XI. **Diagnostic Impression:**

Axis I	
Axis II	Axis III
Axis IV	Axis V Current GAF: Highest GAF in Past Year:

XII. **Plan:**

A. Diagnostic Examinations: _____

B. Laboratory Tests: _____

C. Target Symptoms: _____

_____

_____

D. Psychotherapeutic Needs: _____

_____

E. Medications (name & dosage, amount given): _____

_____

F. Ongoing Plan/Other Issues: _____

_____

Side Effects Discussed: ☐ Yes ☐ No ☐ N/A Ex-Parte: ☐ Yes ☐ No ☐ N/A

Medication Consent Forms: ☐ Yes ☐ No ☐ N/A

Return Appointment	Psychiatrist Signature	Printed Name, Credentials	Date

MEDICATION FOLLOW-UP

WHEN: Each time a client is seen for medication follow-up.

ON WHOM: All clients with a previous psychiatric medication evaluation (completed MHS 645 form) and are currently receiving psychotropic medication.

COMPLETED BY: MD / DO / RN

MODE OF COMPLETION: Legibly handwritten, typed, or word processed on Medication Follow-Up form (MHS-689).

REQUIRED ELEMENTS: Top box shall include the date of service, CPT or HCPCS Code, location of service, Provider Staff ID number, face to face time, total time, DSM-IV-TR Code(s), and corresponding ICD-9-CM Billing Code(s).

The Medication Follow Up shall also include the client's age, date of birth and sex. The Interval History section shall outline signs and symptoms and current compliance level or issues. Tests and Lab Results section shall contain client's height, weight, and vital signs when applicable (for dosing or monitoring side affects, and recommended on a bi-annual basis). Medication Side Effects and Adverse Reactions section shall specify any EPS, tics, anticholinergic, behavioral or medical issues. A Mental Status Exam shall be documented. A Diagnosis shall be documented with Current Treatment, and any Signs and Symptoms. A Medication Plan is to be outlined, specifying medication prescribed, modified, or discontinued with rationale. When applicable, follow-up issues are to be documented, including lab(s) and studies requested. Finally the return appointment shall be noted followed by the psychiatrist's / RN's signature, printed name, credentials, and date Medication Follow-Up was completed.

T Bar shall be completed with the client's name, InSyst number, and program name.

BILLING: After rendering a service, the Medication Follow-Up Form numbered MHA-689 is to be completed adhering to the above documentation standards. The treating physician / RN shall complete the Physician-Nurse Billing Record (see Billing portion of Progress Note section).

Date of Service:	CPT/HCPCS Code:	Location of Service: 1=Office, 2=Field, 3=Phone, 4=Home, 5=School, 6=Satellite, 7=Crisis Field, 8=Jail, 9=Inpatient.
Provider Staff ID:	Face to Face Time: HR: MIN:	Total Time: HR: MIN:
Focus of today's treatment DSM-IV-TR Diagnosis Code(s): _____		ICD-9-CM Billing Code(s): _____

I. Age: _____ **D.O.B.:** _____ **Sex:** _____

II. Interval History (signs and symptoms): _____

Compliance: _____

III. Tests/Lab Results (When applicable indicate Height, Weight, VS's): _____

IV. Medication Side Effects/Adverse Reactions (EPS, tics, anticholinergic, behavioral): _____

V. Mental Status Exam: _____

VI. Diagnosis, Current Treatment, Signs and Symptoms: _____

VII. Medication Plan (prescribed, modified, discontinued with rationale): _____

VIII. Follow-Up Issues (including lab(s) / studies requested): _____

Return Appointment	Psychiatrist / RN Signature	Printed Name, Credentials	Date

PHYSICIAN'S ORDER FORM

WHEN:

When a physician gives a directive for client care that a nurse within the clinic is to follow. Traditionally done in programs which follow a Medical Model. For example, when ordering lab work and vital signs. Not required for out of program physician directives.

ON WHOM:

For any client for whom the MD / DO gives a directive for a nurse in the program to follow.

COMPLETED BY:

MD / DO / RN / LVN / PT

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on Physician's Order form (MHS-985).

REQUIRED ELEMETS:

When MD / DO writes order, the date and time of order given and specific order is noted, followed by the MD / DO signature. The nurse notes the time the order was taken off, and signs the order.

When the nurse receives a verbal or telephone order from the program MD / DO, the nurse indicates the date and time the order was received, outlining whether order was received verbally or by telephone, and prints the ordering MD's / DO's name including the nurse's signature. The specific MD / DO order is written, with the nurse noting the time the order was taken off and signing the order. The MD / DO signs the order within 72 hours of giving a verbal or telephone order.

T Bar shall include the client's name, InSyst number, and program name.

BILLING:

After rendering a service, the appropriate progress note format shall be completed documenting the services rendered. The treating physician / RN / LVN / PT shall complete the Physician-Nurse Billing Record (See Billing portion of Progress Note section).

Date & Time	Orders:	
Time Noted:	Nurse's Signature:	Doctor's Signature:

Date & Time	Orders:	
Time Noted:	Nurse's Signature:	Doctor's Signature:

Date & Time	Orders:	
Time Noted:	Nurse's Signature:	Doctor's Signature:

Date & Time	Orders:	
Time Noted:	Nurse's Signature:	Doctor's Signature:

County of San Diego – CMHS

PHYSICIAN'S ORDER FORM
HHSA:MHS-985 (3/2005)

Client:____________________

InSyst #:____________________

Program:____________________

CHILD / YOUTH HISTORY QUESTIONNAIRE

WHEN:

Within 30 calendar days of opening the client's episode. When client has been in the System of Care, the questionnaire should be requested from the prior provider. If the questionnaire is not received prior to the thirty days, a new questionnaire shall be completed.

ON WHOM:

All clients with open cases, receiving services.

COMPLETED BY:

Parent / guardian, or significant other. When the client is 18 years or older, emancipated, or when no significant other is available, staff member shall complete the questionnaire by gathering any information that is available.

MODE OF COMPLETION:

Legibly handwritten on Child / Youth History Questionnaire form (MHS - 651).

REQUIRED ELEMETNS:

Name of individual completing the form, their relationship to child and date it was completed. Pregnancy / Birth History, Developmental Milestones, Behavioral Symptom Checklist, Child / Youth Medical History Checklist, Family History, and Child / Youth Mental Health History sections to be filled out as completely as possible with comments when applicable and noting when information is unknown. The questionnaire is to be reviewed, signed, and dated by the primary program staff member.

When the questionnaire is imported from another program or previous episode, the current primary staff shall review, sign, and date the questionnaire.

T Bar shall include the client's name, InSyst number, and program name.

BILLING:

Completing the questionnaire and reviewing the responses is often done as part of a session. That contact needs to be summarized in the appropriate progress note format. After rendering a service, the correct progress note form is to be completed adhering to the specific documentation standards (see Progress Note section). A billing record shall be completed for each progress note entry (see Billing portion of Progress Note section).

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

Form Completed By: _____ Relationship To Child: _____ Date Completed: _____

Pregnancy/Birth History

Child's Name: _____ D.O.B: _____ Is Child Adopted: ☐yes ☐no

Did the mother have any medical problems or injuries during pregnancy? ☐yes ☐no ☐unknown
Describe: _____

Did the mother take any medications during pregnancy? ☐yes ☐no ☐unknown
Describe: _____

Did the mother use any drugs or alcohol during pregnancy? ☐yes ☐no ☐unknown
Describe: _____

Did the mother smoke during pregnancy? ☐yes ☐no ☐unknown

Baby's Birth Weight: _____ lbs. _____ oz.

Did the mother take the baby home with her when she left the hospital? ☐yes ☐no ☐unknown

Was the pregnancy or delivery unusual or difficult in any way? ☐yes ☐no ☐unknown
Describe: _____

Did the child have any medical problems in infancy? ☐yes ☐no ☐unknown
Describe: _____

Developmental Milestones

Age child first:

crawled _____
first words _____
bladder control _____
☐ information is unknown

sat up alone _____
weaned _____
bowel trained _____
☐ too long ago to recall

walked alone _____
fed self _____
spoke in complete sentences _____
☐ all within normal limits

Behavioral Symptom Checklist

Speech problems	☐yes	☐no	☐unknown	Unusual or unrealistic fears	☐yes	☐no	☐unknown
Temper tantrums	☐yes	☐no	☐unknown	Aggression toward peers	☐yes	☐no	☐unknown
Head banging	☐yes	☐no	☐unknown	Aggression toward adults	☐yes	☐no	☐unknown
Too active	☐yes	☐no	☐unknown	Aggression toward animals	☐yes	☐no	☐unknown
Impulsive	☐yes	☐no	☐unknown	Aggression toward property	☐yes	☐no	☐unknown
Stubborn	☐yes	☐no	☐unknown	Self-mutilation	☐yes	☐no	☐unknown
Day time wetting	☐yes	☐no	☐unknown	Physically abused	☐yes	☐no	☐unknown
Night time wetting	☐yes	☐no	☐unknown	Sexually abused	☐yes	☐no	☐unknown
Poor bowel control	☐yes	☐no	☐unknown	Sexually active	☐yes	☐no	☐unknown
Sleep problems	☐yes	☐no	☐unknown	Has sexually molested others	☐yes	☐no	☐unknown
Eating problems	☐yes	☐no	☐unknown	Suicide attempts	☐yes	☐no	☐unknown
Withdrawn, shy	☐yes	☐no	☐unknown	Drug use	☐yes	☐no	☐unknown
Fire setting	☐yes	☐no	☐unknown	Alcohol use	☐yes	☐no	☐unknown
Running away	☐yes	☐no	☐unknown	Drug or alcohol treatment	☐yes	☐no	☐unknown
School truancy	☐yes	☐no	☐unknown	Problems with the law	☐yes	☐no	☐unknown
School problems	☐yes	☐no	☐unknown	Juvenile Hall Stay	☐yes	☐no	☐unknown
More interested in things than people	☐yes	☐no	☐unknown	Collects/uses weapons	☐yes	☐no	☐unknown
				Unusual thoughts	☐yes	☐no	☐unknown

Use this area to explain all "yes" answers:

_____

_____

_____

Child / Youth Medical History Checklist

Hearing problems	☐ yes	☐ no	Use this area to explain all "yes" answers:
Vision problems	☐ yes	☐ no	
Diabetes	☐ yes	☐ no	
Ear Infections	☐ yes	☐ no	
High fevers	☐ yes	☐ no	
TB, last tested: _____	☐ yes	☐ no	
Asthma	☐ yes	☐ no	
Allergies: _____	☐ yes	☐ no	
Seizures or loss of consciousness	☐ yes	☐ no	
Serious head injury	☐ yes	☐ no	
Other serious injuries	☐ yes	☐ no	
Medical Hospitalizations	☐ yes	☐ no	
Operations	☐ yes	☐ no	
Serious illness	☐ yes	☐ no	
Child menstruating	☐ yes	☐ no	
Pregnancies, (number: ____)	☐ yes	☐ no	
Venereal diseases: _____	☐ yes	☐ no	
Do you know child's HIV status	☐ yes	☐ no	
Physical exam, date: _____	☐ yes	☐ no	
Dental exam, date: _____	☐ yes	☐ no	

Family History

Have any relatives ever had any of the following conditions?

Alcohol problems	☐ yes	☐ no	☐ unknown	Suicide thoughts	☐ yes	☐ no	☐ unknown
Drug problems	☐ yes	☐ no	☐ unknown	Suicidal attempts	☐ yes	☐ no	☐ unknown
Emotional problems	☐ yes	☐ no	☐ unknown	Mentally retarded	☐ yes	☐ no	☐ unknown
Depression	☐ yes	☐ no	☐ unknown	Arrests	☐ yes	☐ no	☐ unknown
Developmental Delays	☐ yes	☐ no	☐ unknown				

Family Strengths: _____

Child / Youth Mental Health History

Has the child ever seen a psychiatrist or counselor? ☐ yes ☐ no ☐ unknown

Does the child see a psychiatrist or counselor now? ☐ yes ☐ no Who? _____

What mental health diagnosis has child been given? _____

Has the child ever been on medication for behavioral or emotional problems? ☐ yes ☐ no ☐ unknown

Which medications? _____

Child's Psychiatric Hospitalization(s) History (include dates and reasons): _____

Additional comments: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

ADVANCE DIRECTIVE ADVISEMENT

WHEN: Provide clients with written information concerning their rights under federal and state law regarding Advance Medical Directives at the first face to face contact (or when legally required based on age or emancipation status) for services and thereafter upon request by the beneficiary. Federal regulations put this into effect as of June 1, 2004.

ON WHOM: All new adult clients and emancipated minors.

COMPLETED BY: Any program staff member who provided the written instruction.

MODE OF COMPLETION: Legibly handwritten on Advance Directive Advisement form (MHS-611).

REQUIRED ELEMENTS: Check appropriate box to reflect if client has been informed of right to have an Advance Directive (AD); if AD brochure was offered; if client has an executed AD; and when applicable if AD has been placed in medical record when provided by the client. Check box to indicate if client has been informed that complaints concerning noncompliance with AD requirements may be filed with the California Department of Health Services, Licensing and Certification Division at P.O. Box 997413, Sacramento, CA 95899-1413 or by calling 1-800-236-9747. Inform client of right to have AD placed in Medical Record. Staff member who advises client of AD shall sign and date the form.

T Bar shall include the client's name, InSyst number, and program name.

BILLING: Completing the advisement form and reviewing AD information is often done as part of a session. Any additional contact needs to be summarized in the appropriate progress note format. After rendering a service, the correct progress note form is to be completed according to specific documentation standards. A billing record shall be completed for each progress note entry. See the Billing section of the Progress Note for specific billing instructions.

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

NOTE: See Advance Directives Policy and Procedure Number 01-01-130 for additional information.

March, 2005

ADVANCE DIRECTIVE ADVISEMENT

Code of Federal Regulations (CFR) Chapter IV, Part 489.100 defines Advance Directives as: "a written instruction, such as living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."

CRF Section 422.128 requires that all "M+C organizations" maintain written policies and procedures to meet the requirements of informing all adult individuals and emancipated minors receiving medical care by or through the M+C organization about advance directives. This information must reflect consequent changes in State law, no later than 90 days after the effective date of the State law.

As of June 1, 2004 Federal Regulations requires that all NEW adult clients (18 years and older) and emancipated minors be informed of their right to have an Advance Directive (AD). Therefore all clients who turn 18 or become emancipated after June 1, 2004 shall be informed of their right to have an AD. This physical health AD allows the individual to outline the kind of healthcare treatment they want, and who can speak on their behalf when they are not able to communicate their wishes. See County of San Diego Advance Directives Policy and Procedure Number 01-01-130.

Informed client of right to have an Advance Directive: ☑ Yes ☐ No

Offered Advance Directive Brochure: ☑ Yes ☐ No

Client has been informed that complaints concerning noncompliance with AD requirements may be filed with: California Department of Health Services
Licensing and Certification Division
P.O. Box 997413
Sacramento, CA 95899-1413
1-800-236-9747
☑ Yes ☐ No

Does client have an executed Advance Directive: ☐ Yes ☐ No ☐ Client did not disclose

Informed client of right to have AD placed in medical record: ☑ Yes ☐ No
Provided AD shall be attached to this form and placed in client's medical record in Medical Section.

Staff Signature: _____ Date: _____

SECTION VII

ADMINISTRATIVE LEGAL

CONSENT FOR MENTAL HEALTH SERVICES
(County Providers)

WHEN:	Upon initial registration to Mental Health System and annually from date of initial registration.
ON WHOM:	All Mental Health Clients.
COMPLETED BY:	Any program staff member who reviews the parameters of consent.
MODE OF COMPLETION:	Legibly handwritten on Consent for Mental Health Services form (MHS-272).
REQUIRED ELEMENTS:	Outline child's full name for which the consent is being obtained. Client and/or Parent/Legal Guardian signature with date. Clients who are 18 years of age or older or emancipated may consent for their own treatment. Additionally, under some circumstances a minor 12 years and older may consent for their own treatment (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050). T Bar shall include client's name, InSyst number, and program name.
BILLING:	Completing the consent form and reviewing consent information is often done as part of the initial session. After rendering a service, the correct progress note form is to be completed according to specific documentation standards (see Progress Note section). A billing record shall be completed for each progress note entry (see Billing portion of the Progress Note section). Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.
DEPENDENTS & WARDS:	An ex-parte or court order may be utilized to authorize mental health treatment, as well as a form titled Consent for Treatment – Parent (number 04-24P and dated 06/03) which is generated by the Child Welfare Services worker for the parent / guardian to sign.
NOTE:	This is a county form for county providers. Contracted providers are to seek their own legal counsel regarding consent for treatment and appropriate forms.

CONSENT FOR TREATMENT – PARENT

Name of Child:_____ Date of Birth:_____

This Child is: ☐ My Son ☐ My Daughter ☐ A child in my legal custody
This Child is in placement: ☐ Voluntarily ☐ Placed by HHSA or Juvenile Court

I hereby authorize and give my consent for medical, developmental, dental, and mental health care to be given to the above-named child while he or she is in any facility operated by the Health and Human Services Agency of the County of San Diego or any licensed/certified foster home or public or private institution, if the treatment is recommended by a licensed physician, dentist, psychiatrist or other mental health practitioner.

Medical, developmental, dental, or mental health care can include:

- Routine admission and placement examinations including blood test, immunization, and cervical cultures (when indicated).
- X-ray examination, local anesthesia, medical or psychiatric diagnosis or treatment by a licensed physician; or, x-ray examination, laboratory examination, local anesthesia, dental or surgical diagnosis or treatment by a licensed dentist.
- Developmental, speech, occupational and physical therapy evaluation and educational and therapeutic interventions.
- Psychotherapy and counseling within the practitioner's scope of practice.

The following procedures will require a Court order if a parent refuses or is not available to consent to treatment:

Surgery, general anesthesia, spinal tap, blood transfusion, HIV testing, psychotropic medications and non-emergency surgery

I understand that in case of serious illness, psychiatric incident, or accident, a reasonable effort to contact me or my child's other parent will be made before medical, dental, or mental health care is begun, if the time and conditions permit.

List any known allergies or reactions to medication:_____

I prefer treatment by: ☐ Private Physician ☐ Other Licensed Hospital/Medical Facility

Name of Family Physician:_____ Telephone:_____

Type of Medical Insurance:_____ Policy Number:_____

If private treatment is selected and cannot, for any reason, be performed, I hereby authorize treatment at a licensed hospital/medical facility.

This consent will expire upon termination of court jurisdiction or upon termination of voluntary placement agreement.

✕_____ Signed at:_____ Date Signed:_____
Signature of parent or guardian

_____ Telephone:_____
Address of parent or guardian

CONSENTIMIENTO DE TRATAMIENTO - PADRES

Nombre del niño: _____ Fecha de nacimiento: _____

Este niño es: ☐ Mi hijo ☐ Mi hija ☐ Un niño bajo mi custodia legal
Este niño es ubicado: ☐ Voluntariamente ☐ Ubicado por la HHSA o la Corte Juvenil

Con el presente documento autorizo y doy mi consentimiento para que el niño mencionado arriba reciba atención médica, del desarrollo mental, dental y salud mental mientras que este niño o niña se encuentre en cualquier lugar operado por la agencia HHSA del Condado de San Diego o cualquier hogar temporal con licencia o institución pública o privada, si el tratamiento es recomendado por un doctor, dentista, psiquiatra, o cualquier otro profesional en salud mental autorizado.

Esta atención médica, del desarrollo mental, dental, o de salud mental puede incluir:

- Admisión al hospital y exámenes de rutina incluyendo exámenes de sangre, vacunas, y papanicolau (cuando sea indicado).
- Rayos x, anestesia local, diagnosis médicas o psiquiátricas o tratamientos hechos por un médico autorizado; o exámenes con rayos x, exámenes de laboratorio, anestesia local, cirugía dental, diagnosis o tratamiento hecho por un dentista autorizado.
- Evaluación del desarrollo, lenguaje, terapia física y ocupacional e intervenciones educativas y terapéuticas.
- Psicoterapia y consejería dentro del alcance de los practicantes.

Los siguientes procedimientos van a requerir una orden de la Corte si un padre se negara o no fuera capaz de consentir algún tratamiento:

Cirugía, anestesia general, punción lumbar, transfusión sanguínea, exámenes de SIDA, medicamentos psicotrópicos, cirugía no urgente.

Yo entiendo que en el caso de enfermedades graves, incidentes psiquiátricos, o accidente habrá un esfuerzo razonable para comunicarse conmigo o con el padre/madre antes de que algún procedimiento médico, dental, o de salud mental comience si el tiempo y las condiciones lo permitieran.

Haga una lista de cualquier alergia o reacción a algún medicamento: _____

Yo prefiero recibir tratamiento de: ☐ Un Médico Privado ☐ Otro Hospital Autorizado/Centro de Salud

Si el tratamiento privado es seleccionado y no se puede llevar a cabo por alguna razón, yo, con el presente documento, autorizo el tratamiento en algún hospital autorizado o centro de salud.

Esta autorización vencerá Sobre la terminación de la jurisdicción de la corte o sobre la terminación del acuerdo contracto colocación voluntaria.

Nombre del Médico de la Familia: _____ Teléfono: _____

Tipo de Seguro Médico: _____ Número de Póliza: _____

X_____ Firmado en_____ Fecha:_____
Firma del padre/madre o tutor

_____ Teléfono: _____
Domicilio del padre/madre o tutor

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
(County Providers)

WHEN:

Completed to request information from other parties, and/or when releasing information.

ON WHOM:

All clients for whom exchange of information with another party is warranted.

Not schools or CWS

Applicable State and federal law allows for exchange of information between health care providers for the purpose of treatment and payment. Additionally, see DMH Information Notice No.: 04-07 for change in confidentiality of Mental Health Information.

COMPLETED BY:

Staff member who identifies need to request or exchange information on behalf of the client.

MODE OF COMPLETION:

Legibly handwritten or typed on 23-07 HHSA (04/03) form.

REQUIRED ELEMENTS:

- Current date.
- Client information which includes: last name, first name, middle initial, address, city/state, zip code, telephone number, SSN (optional), DOB, and any AKA's.
- Individual or organization authorized to make disclosure.
- Individual or organization to whom the information may be disclosed to and used by.
- Type of information to be disclosed.
- Expiration date, event or condition (when not specified authorization shall expire in one calendar year from the date it was signed).
- Signature of client or legal representative/guardian with date.
- Validation of form with signature and date of provider is optional.
- T Bar shall include client's name, InSyst number, and program name.

Individual who consents to treatment is responsible for authorizations. Clients who are 18 years of age or older or emancipated may sign for their own authorization. Additionally, under some circumstances a minor 12 years and older may sign for authorization (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of the County of San Diego. Our Notice of Privacy Practices provides information about how we may use and disclose your protected medical/health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing the County's web site, www.co.san-diego.ca.us or by contacting any staff person involved in you care.

If you have any questions about our Notice of Privacy Practices, please contact the:

Privacy Officer
County of San Diego Compliance Office
P.O. Box 85524 (Mail Stop: P501)
San Diego, CA 92186-5524
(619) 515-4244

I acknowledge receipt of the Notice of Privacy Practices of the County of San Diego

_____ _____
Signature (Patient/Parent/Conservator/Guardian) Date

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the client's acknowledgement, describe the good faith efforts made to obtain the client's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____ _____ _____
Staff Member's Signature Name and Title Printed Date

Consent For Mental Health Services

This is to authorize San Diego County Children's Mental Health Services to evaluate and or treat
Child's Name: _____

The conditions of the treatment have been explained to me to my satisfaction. I understand that records concerning treatment will be retained. Such data will be kept confidential according to all applicable State and federal laws.

Law compels the County of San Diego, Children's Mental Health Staff, to take action to protect you by informing appropriate person(s) and/or to inform the other person(s) if we believe you are in imminent danger of causing serious harm to yourself or another person(s). Additionally, we are mandated to report any reasonable suspicion that a child, dependent adult, and/or elderly adult have been abused. See Notice of Privacy Practices for complete outline of allowable disclosures.

I have read the above or had it read or explained to me, understand content, and agree to the conditions. I understand that I can withdraw my consent and terminate from this program and its services at any time. This consent will expire upon termination of your current treatment.

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

BILLING:

Completing the authorization form and reviewing authorization issues is often done as part of the session. After rendering a service, the correct progress note form is to be completed according to specific documentation standards. A billing record shall be completed for each progress note entry. See the Billing section of the Progress Note for specific billing instructions.

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

DEPENDENTS & WARDS:

An ex-parte or court order may be utilized to authorize use or disclosure of protected health information.

Authorization to Use or Disclose Protected Health Information – Parent (number 04-24A-P and dated 03/04) is generated by the Child Welfare Services worker for the parent / guardian to sign for the purpose of disclosing protected health information to the Child Welfare Services worker.

Order for Release of Protected Health and Education Information (number 04-24A-C and dated 04/04) is generated by the Courts for the purpose of disclosing protected health information to the Child Welfare Services worker.

SCHOOL:

Authorization for Use or Disclosure of Health Information to School Districts. Dated 10/20/03. May be used for exchange of information with the school.

NOTE:

This is a county form for county providers. Contracted providers are to seek their own legal counsel regarding authorization and appropriate forms.

Assembly Bill No. 715 that was filed with Secretary of State September 29, 2003 requires that authorizations be printed in 14-point type.

Authorization as written is one-directional, allowing the authorized party to disclose information to the party designated to receive the information.

HIPAA forms in threshold languages are available through the County Internet. From the County Website go to: depart/employees, dept/program home pages, Select H (from alpha list), Health and Human Services Agency, Documents, Forms, scroll down and you will see a multitude of HIPAA forms.

COUNTY OF SAN DIEGO

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

			DATE:
PATIENT/RESIDENT/CLIENT			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:	
AKA's:			
THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.			
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:	
ADDRESS	CITY/STATE:	ZIP CODE:	
TELEPHONE NUMBER:	DATE:		
THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION.			
LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:	
ADDRESS	CITY/STATE:	ZIP CODE:	
TELEPHONE NUMBER:	DATE:		
TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.		

County of San Diego

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

_____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:

I agree that a photocopy or fax of this authorization will be as effective as the original.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

County of San Diego

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have right to receive a copy of this authorization. I would like a copy of this authorization.
☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

VALIDATION	
SIGNATURE OF STAFF PERSON VALIDATING INFORMATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER*:	DATE:

CONDADO DE SAN DIEGO

AUTORIZACIÓN PARA USAR O DIVULGAR LA INFORMACIÓN PROTEGIDA DE SALUD

Por medio de este documento, autorizo el uso o divulgación de la información de salud de la persona nombrada según se describe abajo.

			FECHA:
PACIENTE / RESIDENTE / CLIENTE			
APELLIDO:		PRIMER NOMBRE:	INICIAL SEGUNDO NOMBRE:
DIRECCIÓN		CIUDAD/ESTADO:	CÓDIGO POSTAL:
NÚMERO TELEFÓNICO:	Nº DE SEGURO SOCIAL:	FECHA DE NACIMIENTO:	
SEUDÓNIMO:			
LA SIGUIENTE PERSONA U ORGANIZACIÓN ESTÁ AUTORIZADA PARA HACER LA DIVULGACIÓN.			
APELLIDO O ENTIDAD:	PRIMER NOMBRE:		INICIAL SEGUNDO NOMBRE:
DIRECCIÓN	CIUDAD / ESTADO:		CÓDIGO POSTAL:
NÚMERO TELEFÓNICO:	FECHA:		
ESTA INFORMACIÓN SE PUEDE DIVULGAR Y USAR POR LA SIGUIENTE PERSONA U ORGANIZACIÓN.			
APELLIDO O ENTIDAD:	PRIMER NOMBRE:		INICIAL SEGUNDO NOMBRE:
DIRECCIÓN	CIUDAD / ESTADO:		CÓDIGO POSTAL:
NÚMERO TELEFÓNICO:	FECHA:		
FECHAS DE TRATAMIENTO:	PROPÓSITO DE LA SOLICITUD: ☐ A la SOLICITUD DE LA PERSONA.		

SE DEBE REVELAR LA SIGUIENTE INFORMACIÓN: (SÍRVASE MARCAR)	
☐ Historia y examen físico	☐ Órdenes del médico
☐ Resumen de alta	☐ Expedientes de farmacia
☐ Notas de mejoramiento	☐ Expedientes de inmunización
☐ Expedientes de medicamentos	☐ Notas de enfermería
☐ Interpretación de imágenes: radiografías, sonogramas, etc.	☐ Expedientes de facturación
☐ Expedientes de laboratorio	☐ Expedientes de rehabilitación de alcohol/ drogas
☐ Expedientes dentales	☐ Expediente completo
☐ Expedientes psiquiátricos incluyendo consultas	☐ Otro (*Describa*) _____
☐ Resultados de pruebas de sangre VIH/SIDA, toda referencia de estos resultados	

Información delicada Tengo entendido que la información en mi expediente puede incluir información relacionada con las enfermedades de transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA) o infección con el virus de inmunodeficiencia humana (VIH). Asi mismo puede incluir información sobre los servicios de comportamiento o salud mental o tratamiento para abuso de alcohol y drogas.

Derecho a revocar: Tengo entendido que tengo derecho a revocar esta autorización en cualquier momento. Tengo entendido que si revoco esta autorización debo hacerlo por escrito. Tengo entendido que la revocación no se aplica a la información que ya ha sido divulgada basada en esta autorización.

Fotocopia o Fax
Estoy de acuerdo en que una fotocopia o fax de esta autorización sea considerado tan efectivo como el original.

Vencimiento A menos que se revoque de otro modo, esta autorización vencerá en la siguiente fecha, evento o condición:

_____

Si no especifico una fecha, evento o condición de vencimiento, esta autorización vencerá en un (1) año calendario a partir de la fecha en que se firmó.

Redivulgación: Si he autorizado la divulgación de información sobre mi salud a alguien a quien no se le exige legalmente mantenerla confidencial, tengo entendido que puede ser redivulgada y ya no estar protegida. Las leyes de California generalmente prohiben a los destinatarios de mi información de salud sobre la redivulgación de dicha información excepto con mi autorización o según se exija específicamente o se permita por ley.

Otros derechos: Tengo entendido que la autorización para divulgar esta información de salud es voluntaria. Puedo rehusarme a firmar esta autorización. No necesito firmar este formulario para asegurar el tratamiento. Sin embargo, si esta autorización es necesaria para la participación en un estudio de investigación, se puede denegar mi inscripción en el estudio de investigación.

Tengo entendido que puedo revisar u obtener una copia de la información que se usará o divulgará según se estipula en la sección 164.524 del código 45 de las regulaciones federales.

Tengo derecho de recibir una copia de esta autorización. Desearía una copia de esta autorización.

☐ Sí ☐ No

FIRMA DE PERSONA O REPRESENTANTE LEGAL

FIRMA:	FECHA:
SI FIRMA EL REPRESENTANTE LEGAL, PARENTESCO CON LA PERSONA:	

PARA USO OFICIAL	**IDENTIFICACIÓN RATIFICADA**
FIRMA DE MIEMBRO DEL PERSONAL:	FECHA:

FIRMA DEL PROVEEDOR DEL CUIDADO MÉDICO *:	FECHA:

* El Proveedor del cuidado médico que aprueba al cliente acceso a sus propios expedientes.

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION – PARENT

I hereby authorize use or disclosure of the named individual's health information

			TODAY'S DATE:
CLIENT			
LAST NAME:		FIRST NAME:	INITIAL:
ADDRESS:		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:	
AKA'S:			

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.

NAME OR ENTITY: ALL HEALTH AND EDUCATION PROVIDERS, MEDICAL, DENTAL, MENTAL HEALTH AND VISION	
TREATMENT DATES: ALL	PURPOSE OF REQUEST: PURSUANT TO WIC 16010

THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING ORGANIZATION.

NAME OF ENTITY: COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY CHILD WELFARE SERVICES		
ADDRESS	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	DATE:	

THE FOLLOWING INFORMATION IS TO BE DISCLOSED:

☒ All records including, but not limited to:

History and Physical Examination	HIV/AIDS blood test results;
Discharge Summary	any/all references to those results
Progress Notes (psychotherapy)	Physician Orders
Medication Records	Pharmacy records
Interpretation of images: x-rays, sonograms, etc.	Immunization Records
Laboratory results	Nursing Notes
Dental records	Drug/Alcohol Rehabilitation Records
Psychiatric records including Consultations	All Education records

Sensitive Information: I understand that the information in my child's record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing to the Social Worker. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition (parent to initial one):

_____ Upon termination of court jurisdiction or

_____ Upon termination of voluntary placement agreement.

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my child's health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my child's health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, for children who are dependents of the Juvenile Court, the Agency will request the Court to order the release this information.

I understand that Title 45 Code of Federal Regulations section 164.524 may provide me with the right to obtain from my child's medical provider copies of the information to be used or disclosed pursuant to this authorization.

For children in protective custody: I understand that the information contained in my child's health records is needed by HHSA for the purpose of determining the medical, developmental, dental and mental health status of my child to plan for his/her care, while not in my custody. I understand that HHSA may use this information to determine if my child should be made, or continued as a dependent of the Juvenile Court; whether my child should be removed from my custody and control, and if removed, to evaluate my progress in working to regain custody of my child.

I further understand that pursuant to the Welfare and Institutions Code and Superior Court Rules, my child's health and education information will be shared with substitute caregivers, health and education providers, and officers of the Court or other parties in a dependency action in the Juvenile Court, or in subsequent proceedings to appoint a legal guardian or terminate the parental rights entirely.

I have received a copy of this authorization. ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

RELATIONSHIP TO INDIVIDUAL:

AUTORIZACIÓN PARA USAR O DIVULGAR INFORMACIÓN MEDICAL PROTEGIDA DE SALUD - PARIENTE

Por medio de este documento autorizo el uso o divulgación de la información de salud de la persona nombrada según se describe debajo.

		FECHA:
CLIENTE		
APELLIDO:	**PRIMER NOMBRE:**	**INICIAL DE SEGUNDO NOMBRE:**
DIRECCIÓN:	**CIUDAD/ESTADO:**	**CÓDIGO POSTAL:**
NÚMERO TELÉFONO:	**Nº DE SEGURO SOCIAL:**	**FECHA DE NACIMIENTO:**
SEUDÓNIMO/OTRO NOMBRES:		
LA SIGUIENTE PERSONA O ORGANIZACIÓN ESTÁ AUTORIZADA HACER LA DIVULGACION.		
NOMBRE O ENTIDAD: TODOS PROVEDORS MEDICAL, DENTAL, SALUD MENTAL, VISION, Y EDUCACION.		
FECHAS DE TRATAMIENTO: TODAS	**PROPÓSITO DE LA SOLICITUD:** SEGÚN WIC §16010	
ESTA INFORMACIÓN SE PUEDE DIVULGAR Y USAR POR LA SIGUIENTE PERSONA U ORGANIZACIÓN.		
APELLIDO O ENTIDAD: Condado de San Diego Agencia de Salud y Servicios Humanos (HHSA) - Servicios de Bienestar para Niños		
DIRECCIÓN:	**CIUDAD / ESTADO:**	**CÓDIGO POSTAL:**
NÚMERO TELEFÓNICO:	**FECHA:**	

LA SIGUIENTE INFORMACIÓN DEBE SER DIVULGADA:

☒ TODOS RECORDS INCLUYENDO, PERO NO LIMITADO A LOS SIGUENTES:

- Historia y examen físico
- Resumen de alta
- Notas de mejoramiento (Psicoterapia)
- Record de medicamentos
- Interpretación de imágenes: radiografías, sonogramas, etc.
- Record de laboratorio
- Record dentales
- Record psiquiátricos incluyendo consultas
- Resultados de pruebas de sangre VIH/SIDA, y todas referencias de estos resultados
- Órdenes del médico
- Record de farmacia
- Record de inmunización
- Notas de enfermería
- Record de rehabilitación de alcohol/ drogas
- Récord de educación

Información delicada: Entendido que la información en el record medicar de mi hijo(a) puede incluir información relacionada a enfermedades de transmisión sexual, síndrome de inmunodeficiencia adquirida (SIDA) o infección con el virus de inmunodeficiencia humana (VIH). También puede incluir información sobre los servicios de comportamiento o salud mental o tratamiento para abuso de alcohol y drogas.

Derecho a revocar: Entiendo que tengo el derecho de revocar esta autorización en cualquier momento. Entiendo que si revoco esta autorización debo hacerlo por escrito a la Trabajadora Social. Entiendo que la revocación no aplica a la información que ya ha sido divulgada basada en esta autorización.

Vencimiento: A menos que se revoque de otro modo, esta autorización vencerá en la siguiente fecha, evento o condición: (padre al inicial uno):

_____ Sobre la terminación de la jurisdicción de la corte o

_____ Sobre la terminación del acuerdo contracto colocación voluntaria.

Si no especifico una fecha, evento o condición de vencimiento, esta autorización vencerá en un (1) año calendario a partir de la fecha en que se firmó.

Redivulgación: Si he autorizado la divulgación de información medica sobre mi hijo(a) a alguien que no se le exige legalmente mantenerla confidencial, entiendo que puede ser redivulgada y ya no estar protegida. Las leyes de California generalmente prohíben a los destinatarios de mi información de salud sobre la redivulgación de dicha información excepto con mi escrita autorización o según se exija específicamente o se permita por ley.

Otros derechos: Entiendo que la autorización para divulgar esta información de salud es voluntaria. Puedo rechazar firmar esta autorización. Sin embargo paras niños que son dependientes de la Corte Juvenil, la Agencia solicitara de la Corte que ordene la divulgación de esta información.

Entiendo que la sección 164.524 del código 45 de las regulaciones federales quizá me proveer con el derecho para obtener de me hijo(a) proveedor medicar copias de la información que se usará o divulgará según esta autorización.

Para niños en custodia protectiva: entiendo que HHSA necesita la información en el registro de salud de mi hijo(a) es para determinar el estado médico, desarrollo, dental y salud mental de mi hijo(a), para planear para su cuidado mientras no esta en mi custodia. Entiendo que HHSA puede utilizar esta información para determinar si mi hijo debe ser echo, o continuar como un dependiente de la Corte Juvenil; para determinar si mi hijo(a) debe ser separado de mi custodia y control, y si separado, para evaluar si estoy progresando para recuperar custodia de mi niño.

Entiendo que según el Código de Bienestar y Instituciones y las Reglas de la Corte Superior, la salud de mi hijo y información de educación será compartida con padres de crianza/pariente, con proveedores de salud y educación, y con los oficiales de la Corte y otros participantes en la acción de dependencia en la Corte Juvenil, o en actos subsiguientes para designar una tutela legal o terminar los derechos de los padres enteramente.

Recibí una copia de esta autorización. ☐ Sí ☐ No

FIRMA DE PERSONA O REPRESENTANTE LEGAL

FIRMA:	FECHA:

RELACION A LA PERSONA:

APPLICATION FOR AN ORDER
FOR RELEASE OF PROTECTED HEALTH AND EDUCATION INFORMATION

Child:	DOB:	Petition #:
Parent(s):		Case #:
Caregiver:		Caregiver's Relationship:
Caregiver's Address:		Phone #:
Social Worker:		Phone #:
Child's Attorney:		Phone #:

All records related to the treatment of the above named child shall be made available upon request to the Court, the child's attorney and the Health and Human Services Agency, Child Welfare Services by all individuals, agencies and entities that are either paying for or providing health, psychological treatment, assessment and/or education services to the above named child.

These individuals, agencies and entities include: schools, hospitals, laboratories, health insurers, health plans, health maintenance organizations, employers, clinics, physicians, psychologists, psychotherapists, counselors and any other individual or entity providing education and/or health, psychological treatment or assessment services to the child.

All records including, but not limited to:

History and Physical Examination	HIV/AIDS blood test results; any/all
Discharge Summary	references to those results
Progress Notes (psychotherapy)	Physician Orders
Medication Records	Pharmacy records
Interpretation of images: x-rays, sonograms, etc.	Immunization Records
Laboratory results	Nursing Notes
Dental records	Drug/Alcohol Rehabilitation Records
Psychiatric records including Consultations	All Education records

---

This Order shall remain in effect for the duration of the dependency case.

SO ORDERED: Date _____

_____
JUDGE/REFEREE OF THE JUVENILE COURT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:_____ / _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
(1) _____ (2) _____
to provide health information from the above-named child's medical record to and from:

_____ _____
School District to Which Disclosure is Made Address / City and State / Zip Code

_____ _____
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ❑ All health information; **or** ❑ Disease-specific information as described:

_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (*enter date*) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION
(County Providers)

WHEN: Upon request for access and/or copy of medical record or excerpts from medical record.

ON WHOM: All Mental Health Clients.

COMPLETED BY: Client and/or guardian.

MODE OF COMPLETION: Legibly handwritten or typed on 23-01 HHSA (04/03).

REQUIRED ELEMENTS:

- Date.
- Client information to include last name, first name, middle initial, address, city/state, zip code, any AKA's, telephone number, SSN (optional), and DOB.
- Representative information, when client/guardian wishes to have information given to another person or entity.
- Check or listing of information that is being requested.
- Beginning and end date of search.
- Where and how information is being requested (in person, mail, specific location).
- Signature and date of client and/or legal guardian submitting request.
- Staff member processing the request shall sign and date form as well as complete T Bar information to include the client's name, InSyst number, and program name.

Individual who consents to treatment may submit request. Clients who are 18 years of age or older or emancipated may submit their own request. Additionally, under some circumstances a minor 12 years and older may submit their own request (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).

BILLING: Request is done by the client/guardian and is not a service provided by the program. Gathering and photocopying the information is clerical and therefore not billable. However, when request is discussed in a clinical context and/or information is reviewed with the client and/or guardian from a clinical perspective that service is to be summarized in the appropriate progress note form. Note is completed according to specific documentation standards. A billing record shall be completed for each progress note entry. See the Billing section of the Progress Note for specific billing instructions.

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

NOTE: This is a county form for county providers. Contracted providers are to seek their own legal counsel. Form available on County Internet.

March, 2005

COUNTY OF SAN DIEGO

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION

You have the right to request to review your personal health information we create or maintain. You also have the right to request copies of those records for which you will be charged $.15 per page. Within five (5) business days after we receive your request to access your record, one of our staff will contact you to set an appointment for you to review your records or we will inform you in writing that we have denied your request for access and state the reason why. After you have completed this form, you need to mail or return it to:

SAN DIEGO COUNTY MENTAL HEALTH
P.O. BOX 85524
SAN DIEGO, CA 92186-5524
(619) 692-5700 EXT 3

	DATE:

PATIENT/RESIDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
AKA'S		

TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

REPRESENTATIVE INFORMATION

(Complete only if you want us to give your information to another person or entity.)

I authorize the following person to receive the requested information.

LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
RELATIONSHIP:	TELEPHONE NUMBER:	

PERSONAL HEALTH INFORMATION TO WHICH YOU WANT ACCESS

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____ _____ _____

From what dates do you want information *(period of time)*

Date to begin search:	Date to end search:

ACCESS METHOD AND LOCATION	
Where and when do you want to inspect or receive copies of your information:	
IN PERSON: ☐ YES	LOCATION:
COPIES BY MAIL: ☐ YES	
YOUR SIGNATURE	
SIGNATURE:	DATE:

FOR OFFICE USE

VALIDATION	
SIGNATURE OF STAFF PERSON VALIDATING INFORMATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER*:	DATE:

There is a charge to every client who receives services.

This applies to the initial screening or intake visit as well as other times.

You will be asked to provide information regarding your income.

YOU MAY HAVE TO PAY FOR ALL, SOME, OR NONE OF THE COST

The amount you will pay will depend on your monthly gross income, liquid assets, and the number of your allowed dependants. This will be determined in accordance with California Law – a law which is used by every County Mental Health Facility in California. It is your responsibility to call and discuss with the Human Service Specialist, within ten (10) days from the initial visit, your financial information in order to determine the cost of the care based on the Sliding Scale Fee. It is also your responsibility to inform the Human Services Specialist when there is a change in your employment or income. Changes in income may increase or decrease the amount you are responsible for paying.

You must notify the Human Service Specialist if you are covered with any of the following health care coverage: Private or Group Health Insurance, Military (Champus) or Veterans Administration (Champus VA) Health Insurance, Medi-Cal, Medicare, Healthy Families, Worker's Compensation or Prepaid Health Insurance. The above health insurance may or may not cover part or the entire cost of care.

Client Name:_____DOB:_____

Client Signature: _____

Responsible Party or Representative:_____

Relationship to client:_____

Date of Signing: _____

Name of Witness:_____ Title:_____

Please Contact The Human Service Specialist:

Name: _____

Phone Number: _____

ACKNOWLEDGEMENT OF RECIPT
County of San Diego – Health Care Provider
Notice of Privacy Practices
(County Providers)

WHEN:	Upon initial registration to Mental Health System, or upon client/guardian's request. However, if a copy of original Acknowledgment of Receipt is not obtained from previous or concurrent county provider or previous episode, current provider is to provide/offer County of San Diego's Notice of Privacy Practices and obtain Acknowledgment of Receipt.
ON WHOM:	All Mental Health Clients.
COMPLETED BY:	Client/guardian and/or any program staff member who provides the County of San Diego's Notice of Privacy Practices.
MODE OF COMPLETION:	Legibly handwritten on Acknowledgement of Receipt form (NPP 03-21-03)
REQUIRED ELEMENTS:	Signature of client/parent/conservator/guardian and date. Staff member is to sign the form with printed name, title and date when no signature is obtained. An outline of good faith efforts made to obtain client's acknowledgement and the reasons why the acknowledgement was not obtained is to be outlined on the form with the staff member's signature, printed name and title and date. T Bar shall include client's name, InSyst number, and program name.
BILLING:	Completing the form and reviewing/providing the Notice of Privacy Practices of the County of San Diego is often done as part of the initial session. After rendering a service, the correct progress note form is to be completed according to specific documentation standards (see Progress Note section). A billing record shall be completed for each progress note entry (see Billing portion of the Progress Note section). <u>Day Programs</u> provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.
DEPENDENTS & WARDS:	Notice of Privacy Practices should be provided to the Child Welfare Services worker. Complete the "Inability to Obtain Acknowledgement" section, outlining the good faith efforts made and reason for not obtaining the acknowledgement.
NOTE:	This is a county form for county providers. Contracted providers are to seek their own legal counsel regarding Notice of Privacy Practices requirements. Notice can be obtained at www.co.san-diego.ca.us

March, 2005

SECTION VIII

INTERAGENCY REPORTS

Dependency Court Reports
Probation Reports
Regional Center Reports
Social Security Disability
Other

SECTION IX

SCHOOL REPORTS

IEP's
IEP Meeting Notes
Report Cards
Teacher Observations
Other

SECTION X

CORRESPONDENCES

Correspondence received (letters, fax cover sheets)
Correspondence sent out (copies of letters, etc)
Request for treatment records
Other

SECTION XI

PREVIOUS TREATMENT

Previous medical records
Residential placements
Psychological testing and evaluations
Other